NOTE: Complete both sides of this page for ALL annual reports

State of California
Department of Industrial Relations
Self Insurance Plans
2265 Watt Avenue, Suite 1
Sacramento, CA 95825
Web site http://sip.dir.ca.gov
E-mail: sip@dir.ca.gov

Fiscal Year Ending **June 30, 2005**

PUBLIC SELF INSURER'S ANNUAL REPORT FOR NON-JPA MEMBER

I. GENERAL

1. CERTIFICATE NUMBER:
☐-☐☐☐☐-☐☐-☐☐☐
☐ Active ☐ Revoked

2. PERIOD OF REPORT:
☐ Full Year ☐ Interim/Amended Report for the Period of:
Month Day Year to Month Day Year

3. NAME OF MASTER CERTIFICATE HOLDER (JPA):

_____ Federal Tax Identification No.:

_____ _____
ADDRESS OF MAIN HEADQUARTERS

_____
CITY STATE ZIP + 4

4. TYPE OF PUBLIC AGENCY:
☐ CITY/COUNTY ☐ POLICE/FIRE ☐ TRANSIT
☐ SCHOOL ☐ HOSPITAL ☐ OTHER

5. During the period of this report, has there been any of the following with respect to the master certificate holder, subsidiary or affiliate certificate holder?

A merger or unification?	Yes ☐	No ☐
Changes in name or identify	Yes ☐	No ☐
Any addition to Self Insurance Program?	Yes ☐	No ☐

If yes, explain: _____

_____

6. Are there any agency employees NOT included in your Workers' Compensation Self Insurance Program?

☐ Yes ☐ No

If yes, what employees are not included? _____

Are these employees covered by an insurance policy? Yes ☐ No ☐

Are these employees covered by another self insurance cert. or JPA? Yes ☐ No ☐

7. TO WHOM DO YOU WANT CORRESPONDENCE ADDRESSED?

NAME/TITLE: _____

COMPANY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP+4: _____

PHONE: (____) _____ FAX: (____) _____

E-MAIL ADDRESS: _____

8. CERTIFICATION BY AGENCY OFFICIAL:
I declare under the penalty of perjury that I have examined this Self Insurer's Annual Report and to the best of my knowledge and believe it is true, correct and complete.

Signature (Original Only): _____ Date: _____

Typed Name: _____

Agency Name: _____

Street Address: _____

City: _____ State: _____ Zip +4 _____

Phone: (____) _____ Fax: (___) _____

Fiscal Year
04/05

ANNUAL REPORT IS DUE OCTOBER 1, 2005

NOTE: **Claims Administrator**
Complete this page for ALL reports except item B Employment/Wages, which is completed by Self Insured employer.

Fiscal Year Ending **June 30, 2005**

II. CONSOLIDATED LIABILITIES

Certificate Number: ☐-☐☐☐☐-☐☐-☐☐☐

Name of Master Certificate Holder: _____

Type of Report:

☐ **Original** Report (Due October 1 each year)

☐ Interim/Amended Report for the Period of:

From Date: Month Day Year To Date: Month Day Year

A. CASES AND BENEFITS (to nearest dollar)

	Number	Incurred Liability		Paid to Date		Future Liability	
		$ Indemnity	$ Medical	$ Indemnity	$ Medical	$ Indemnity	$ Medical
1. Cases open as of 6/30/2005 reported prior to FY 2000-01							
2. Open & Closed Cases:							
a. FY 2000-01 Total cases Reported							
FY 2000-01 Cases open							
b. FY 2001-02 Total Cases Reported							
FY 2001-02 Cases Open							
c. FY 2002-03 Total Cases Reported							
FY 2002-03 Cases Open							
d. FY 2003-04 Total Cases Reported							
FY 2003-04 Cases Open							
e. FY 2004-05 Total Cases Reported							
FY 2004-05 Cases Open							

	$ Indemnity	$ Medical
SUBTOTAL		
3. ESTIMATED FUTURE LIABILITY (Indemnity plus Medical) **TOTAL**		

	$ Indemnity	$ Medical
4. Total Benefits paid during FY 2004-05 (including all case expenditures):		

5. Number of MEDICAL-ONLY cases reported in FY 2004-05: _____

6. Number of INDEMNITY cases reported in FY 2004-05: _____

7. TOTAL of 5 and 6 (also entered in 2e above): _____

8. TOTAL number of open indemnity cases (all years): _____

9. Number of Fatality cases reported in FY 2004-05: _____

10. (a) Number of FY 2004-05 claims for which the employer or administrator was notified of representation by an attorney or legal representative in FY 2004-05: _____

10. (b) Number of non-FY 2004-05 claims for which the employer or administrator was notified of representation by an attorney or legal representative in FY 2004-05: _____

B. TOTAL EMPLOYMENT AND WAGES PAID IN FISCAL YEAR 2004-2005 FOR THIS SELF INSURER:

(a) NUMBER OF EMPLOYEES _____
(Number of individual employees listed on for DE-6 for year ending June 30, 2005)

(b) TOTAL WAGES AND SALARIES PAID $ _____
(As reported on EDD Form DE-6 Line M for all four quarters)

Fiscal Year 04/05

A. NAME OF ADMINISTRATOR(S)/ADMINISTRATING AGENCY(IES) SUBMITTING THIS REPORT.

1. Name (Person) _____ **Administrative Agency's**

Agency Name _____ **Certificate No.:** ☐☐☐

Address _____ **or** ☐ **Self Administered**

City _____ **State** _____ **Zip+4** _____

B. HAS THERE BEEN A CHANGE IN ADMINISTRATOR/ADMINISTRATIVE AGENCY DURING THE PERIOD OF THIS REPORT PERIOD? ☐ **YES** ☐ **NO**

IF YES: DATE OF CHANGE: ☐☐☐☐☐☐
Month Day Year

TYPE OF CHANGE: ☐ **Change in Administrative Agency**
☐ **Change to or from Self Administration**

NAME OF NEW ADMINISTRATOR(S)/ADMINISTRATIVE AGENCY(IES):

Name _____

Agency Name _____

Address _____

City _____ **State** _____ **Zip+4** _____

CERTIFICATION

I declare under penalty of perjury that I have prepared or caused this report to be prepared and I have examined this liabilities report of this self insurer's workers' compensation liabilities. To the best of my knowledge and belief this report is true, correct and complete with respect to the workers' compensation liabilities incurred and paid. I further declare under the penalty of perjury that the estimates of future liability of workers' compensation claims made in this report reflect the administrator's best judgment astothe future liability of claims, using prevailing industry standards, and the signatory intends Self Insurance Plans to rely upon the representation.

_____ _____
Original Signature of Administrator (Qualified Person) **Date**

_____ _____
Typed Name of Administrator **Name of Administrative Agency or Employer**

_____ _____
Title **Street Address**

_____
City **State** **Zip+4**

Phone No. of Administrator (**)** _____ **Fax No. (** **)** _____
area code **area code**

E-mail Address of Administrator _____

Fiscal Year
04/05

NOTE: **Claims Administrator**
Complete this page for each adjusting location where there are at least two adjusting locations

II. LIABILITIES BY REPORTING LOCATION

Reporting Location Nos.: ☐-☐☐☐☐-☐☐-☐☐☐

Name/Identification of Location: _____
OR
Name of Subsidiary/Affiliate Certificate Holder: _____

Type of Report:

☐ **Original** Report (Due October 1 each year)

☐ Interim/Amended for the Period of:

From Date: ☐☐ Month ☐☐ Day ☐☐ Year To Date: ☐☐ Month ☐☐ Day ☐☐ Year

A. CASES AND BENEFITS (to nearest dollar)

	Number	Incurred Liability		Paid to Date		Future Liability	
		$ Indemnity	$ Medical	$ Indemnity	$ Medical	$ Indemnity	$ Medical
1. Cases open as of 06/30/2005 reported prior to FY 2000-01							
2. Open & Closed Cases:							
a. FY 2000-01 Total cases reported							
FY 2000-01 Cases Open							
b. FY 2001-02 Total cases reported							
FY 2001-02 Cases Open							
c. FT 2002-03 Total Cases reported							
FY 2002-03 Cases Open							
d. FY 2003-04 Total Cases reported							
FY 2003-04 Cases Open							
e. FY 2004-05 Total Cases Reported							
FY 2004-05 Cases Open							

	$ Indemnity	$ Medical
SUBTOTAL		
TOTAL		

3. ESTIMATED FUTURE LIABILITY (Indemnity plus Medical)

$ Indemnity	$ Medical

4. Total Benefits paid during FY 2004-05 (including all case expenditures): . . . . . .

5. Number of MEDICAL-ONLY cases reported in FY 2004-05: . . . . . _____

6. Number of INDEMNITY cases reported in FY 2004-05: . . . . . _____

7. TOTAL of 5 and 6 (also entered in 2e above): . . . . . _____

8. TOTAL number of open indemnity cases (all years): . . . . . _____

9. Number of Fatality cases reported in FY 2004-05: . . . . . _____

10. (a) Number of 2004 claims for which the employer or administrator was notified of representation by an attorney or legal representative in FY 2004-05: . . . . . _____

10. (b) Number of non-2004 claims for which the employer or administrator was notified of representation by an attorney or legal representative in FY 2004-05: . . . . . _____

Fiscal Year 04/05

A. NAME OF ADMINISTRATOR(S)/ADMINISTRATING AGENCY(IES) SUBMITTING THIS REPORT.

1. Name (Person) _____ **Administrative Agency's**

Agency Name _____ **Certificate No.:** ☐☐☐

Address _____ **or** ☐ **Self Administered**

City _____ **State** _____ **Zip+4** _____

B. HAS THERE BEEN A CHANGE IN ADMINISTRATOR/ADMINISTRATIVE AGENCY DURING THE PERIOD OF THIS REPORT PERIOD? ☐ **YES** ☐ **NO**

IF YES: DATE OF CHANGE: ☐☐☐☐☐☐
Month Day Year

TYPE OF CHANGE: ☐ **Change in Administrative Agency**
☐ **Change to or from Self Administration**

NAME OF NEW ADMINISTRATOR(S)/ADMINISTRATIVE AGENCY(IES):

Name _____

Agency Name _____

Address _____

City _____ **State** _____ **Zip+4** _____

CERTIFICATION

I declare under penalty of perjury that I have prepared or caused this report to be prepared and I have examined this liabilities report of this self insurer's workers' compensation liabilities. To the best of my knowledge and belief this report is true, correct and complete with respect to the workers' compensation liabilities incurred and paid. I further declare under the penalty of perjury that the estimates of future liability of workers' compensation claims made in this report reflect the administrator's best judgment astothe future liability of claims, using prevailing industry standards, and the signatory intends Self Insurance Plans to rely upon the representation.

_____ _____
Original Signature of Administrator (Qualified Person) **Date**

_____ _____
Typed Name of Administrator **Name of Administrative Agency or Employer**

_____ _____
Title **Street Address**

_____
City **State** **Zip+4**

Phone No. of Administrator (**)** _____ **Fax No. (** **)** _____
area code **area code**

E-mail Address of Administrator _____

Fiscal Year
04/05

IV. RECORDS STORAGE

1. Are claim records stored at any location other than with the current administrator?

☐ **Yes** ☐ **No** **If yes, Where?** _____

A. Agency Name _____
Address _____
City _____ **State** ____ **Zip+4** _____
Phone ( ) _____

B. Agency Name _____
Address _____
City _____ **State** ____ **Zip+4** _____
Phone ( ) _____

C. Agency Name _____
Address _____
City _____ **State** _____ **Zip+4** _____
Phone ( ) _____

D. Agency Name _____
Address _____
City _____ **State** _____ **Zip+4** _____
Phone ( ) _____

V. INSURANCE COVERAGE

1. Are any of your workers' compensation liabilities in California during the reporting period covered by a standard workers' compensation insurance policy?

☐ **Yes** ☐ **No** **If Yes:**

1. Name of Insurance Company: _____
Policy Number: _____ **Policy Issue Date:** _____
2. Name of Insurance Company: _____
Policy Number: _____ **Policy Issue Date:** _____

2. Are any of your workers' compensation liabilities in California during the reporting period covered by a specific excess workers' compensation insurance policy?

☐ **Yes** ☐ **No** **If Yes:**

1. Name of Carrier: _____
Policy Number: _____ **Policy Issue Date:** _____
Retention Limit: _____
2. Name of Carrier: _____
Policy Number: _____ **Policy Issue Date:** _____
Retention Limit: _____

3. Do you carry an aggregate (stop loss) workers' compensation insurance policy?

☐ **Yes** ☐ **No** **If Yes:**

1. Name of Carrier: _____
Policy Number: _____ **Policy Issue Date:** _____
Retention Limit: _____
2. Name of Carrier: _____
Policy Number: _____ **Policy Issue Date:** _____
Retention Limit: _____

VI. OPEN INDEMNITY CLAIMS

A. List of *ALL* Open Indemnity Claims by reporting location and by year reported and with claims in alphabetical order is attached immediately following page 6 of this report. (You may use the form attached or a computer prepared printout organized in the same format.)

Fiscal Year
04/05

VII. FUNDING OF LIABILITIES

Certificate Number: ☐-☐☐☐☐-☐☐-☐☐☐

Name of Master Certificate Holder: _____

1. Which of the following best describes the method your agency uses to fund the outstanding workers' compensation claim liabilities?

☐ Actuary Basis

☐ Cash Flow Basis

☐ Fixed Amount in Agency Budget - Amount is $_____

☐ Percentage Above Last Year's Losses - Percentage is: _____ %
- Total Amount Available is: $_____

☐ Agency Does Not Fund Workers' Compensation Liabilities

☐ Other: _____

2. Does your agency fund for incurred but not reported workers' compensation claims in addition to know or reported claims?

☐ Yes ☐ No If yes, Amount: $_____

3. Is the workers' compensation funding restricted or set aside solely to pay the agency's workers' compensation liabilities?

☐ Yes ☐ No

If yes, what was the amount set aside as of June 30, 2005? _____

4. Does your agency have an outside, independent claims auditor review your case reserve practices and general claims management?

☐ Yes ☐ No

If yes, what was the date of the last such audit?_____

5. Does your agency have an outside, independent actuary to review future liability funding?

☐ Yes ☐ No

If yes, what was the date of the last such review?_____

Fiscal Year
04/05

LIST OF OPEN INDEMNITY CASES

AS OF _____

(Date)

Reporting Location No.: _____

Certificate Number: _____

All Cases on this Page are

For the Year _____

NAME OF MASTER CERTIFICATE HOLDER: _____

Name of Insured or Deceased (Last) (First Initial)	Date of Injury	Description of Injury	Paid to Date		Estimated Future Liability	
			$ Indemnity	$ Medical	$ Indemnity	$ Medical
(List Alphabetically within year)						

Fiscal Year
04/05